Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
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Original Public Report

Report Issue Date: March 4, 2024

Inspection Number: 2023-1346-0005

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Waterdown Long Term Care Centre Inc.

Long Term Care Home and City: Alexander Place, Waterdown

Lead Inspector	**Inspector Digital Signature**
Emma Volpatti (740883)	

Additional Inspector(s)
Dusty Stevenson (740739)
Waseema Khan (741104)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 8-12, 15-16, 18-19, 22-26, 29-30, 2024.

The following intake(s) were inspected:

- Intake #00097234 [Critical Incident (CI) #2861-000031-23] - related to infection prevention and control.
- Intake #00099340 [CI # 2861-000035-23] - related to the prevention of abuse and neglect.
- Intake #00099638 [CI #2861-000036-23] - related to nutrition and dietary services.

- Intake #00101958 - Follow-up #1 from inspection 2023-1346-0004 - related to medication management.
- Intake #00102884 - Complaint related to skin and wound prevention and management, responsive behaviours and discharge.
- Intake #00104087 [CI #2861-000047-23] - related to falls prevention and management.
- Intake #00107319 [CI #2861-000006-24] - related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1346-0004 related to O. Reg. 246/22, s. 123 (3) (a) inspected by Emma Volpatti (740883).

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A) The licensee has failed to ensure that a resident was protected from neglect.

Rationale and Summary
O. Reg. 246/22 s. 7 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On an identified morning, a resident's bed was soiled. The resident was reliant on staff to for assistance with continence care.

A Registered Practical Nurse (RPN) verified that the resident experienced a skin alteration upon assessment.
A Personal Support Worker (PSW) stated that the bed linen was required to be changed every time the bed linen is soiled. A Co-Director of Care (Co-DOC) acknowledged that the bed linen needed to be changed, and it was not done.

Sources: A resident's clinical record, investigation notes, interview with staff.
[741104]

B) The licensee has failed to ensure that a resident was protected from neglect.

Rationale and Summary
On an identified morning, a resident's bed was wet with urine. The resident was reliant on staff to assist with continence care.

An RPN verified that the resident experienced a skin alteration upon assessment. A PSW stated that the bed linen was required to be changed every time the bed linen is soiled. A Co-DOC acknowledged that the bed linen needed to be changed, and it was not done.

Sources: A resident's clinical record, licensee's investigation notes, interview with staff. **[741104]**

C) The licensee has failed to ensure that a resident was protected from neglect.

Rationale and Summary
On an identified morning, a resident's bed was soiled. The resident was reliant on staff to assist them with continence care.

An RPN verified that the resident experienced a skin alteration upon assessment. A PSW stated that the bed linen was required to be changed every time the bed linen is soiled. A Co-DOC acknowledged that the bed linen needed to be changed and it was not done.

Sources: A resident's clinical record, licensee's investigation notes, interview with staff. **[741104]**

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 3.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:

3. The effectiveness of the plan of care.

The licensee has failed to document the effectiveness of a trial of diet modification for a resident when it was ordered by the Registered Dietitian (RD).

Rationale and Summary
An order was written by an RD for a resident to trial a specific diet texture and to document in progress notes for seven days. According to the electronic documentation, the resident was provided the diet texture trial and registered staff initialed it as completed.

Documentation was reviewed and a note detailing the effectiveness of the diet texture trial was only completed by one registered staff.

Staff verified in an interview that a note should have been documented when trialing the diet texture for the resident.

Sources: A resident's clinical records, interview with a staff. **[740739]**

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee has failed to ensure that protocols for the referral of residents to specialized resources where required were co-ordinated and implemented on an interdisciplinary basis.

Rationale and Summary
A resident was admitted to the home and displayed responsive behaviours. The resident's Physician (MD) ordered for them to be referred to a specialized resource. Review of their clinical record indicated the referral was sent three months after it was ordered.

The Director of Care (DOC) acknowledged that the referral was not sent as soon as it was ordered for the resident.

Failing to refer the resident to a specialized resource when required posed a risk of a delay in treatment being provided.

Sources: Interview with the DOC, a resident's clinical records, the home's policy. **[740883]**

WRITTEN NOTIFICATION: Explanation of Plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (12)
Plan of care
s. 6 (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care.

The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was given an explanation of the plan of care.

Rationale and Summary
A resident had a reoccurring skin alteration. The residents SDM indicated to staff that they thought the resident should see a specialist. Staff indicated they could not do anything until the MD ordered a referral. During a one-month period, the resident's SDM requested on two more occasions that referral be sent. The resident

was subsequently referred at the end of the month period.

The DOC acknowledged that the referral was not initially completed as the MD did not feel a referral was warranted. They acknowledged an explanation should have been provided to the SDM when they were requesting the referral.

Failing to provide a resident's SDM an explanation of the plan of care led to the SDM not being updated on the resident's care needs.

Sources: Interview with the DOC and other staff, a resident's clinical record.
[740883]

WRITTEN NOTIFICATION: Access to Plan

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (14)
Plan of care
s. 6 (14) Nothing in this section limits a right of access to a plan of care under the Personal Health Information Protection Act, 2004.

The licensee has failed to ensure that resident a resident's SDM had access to their plan of care under the Personal Health Information Protection Act, 2004.

Rationale and Summary
A resident's SDM provided a request form to the Administrator to obtain parts of a resident's medical record. The Administrator then forwarded the request to their manager.

The Administrator acknowledged that the records were never provided to the SDM and a new request form was done.

Sources: Interview with the Administrator, a resident's clinical record, the home's

policy. **[740883]**

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee has failed to monitor a resident, as per the Falls Prevention and Management Program, by completing falls risk assessment as required to a potential injury after they sustained a fall.

Rationale and Summary
In accordance with O. Reg 246/22, s.11 (1) (b), the home's policy under their Falls Prevention and Management Program directed that a Falls Risk Assessment is completed on admission, quarterly and as required.

A resident had an unwitnessed fall and returned from the hospital the next day with a specified diagnosis. Interview with a PSW verified that the resident was in pain.

Two registered staff confirmed that there was a significant change in the resident and their falls risk assessment was not completed after the fall.

The DOC confirmed that a fall risk assessment indicates if a resident is at a high risk for falls and what interventions should be in place. The resident's falls risk assessment was not completed after they had a fall.

There was an increased risk, when a fall risk assessment was not done for

monitoring the resident as required following the fall.

Sources: A resident's clinical notes, assessments, licensee's policy, interviews with a PSW and other staff. **[741104]**

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
A resident had a reoccurring skin impairment, which was documented as resolved on an identified date. Two months after the last assessment, the resident's MD documented that they assessed the resident and the skin impairment had returned.

Review of the resident's clinical record indicated there was no skin assessment completed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A Co-DOC acknowledged that a comprehensive skin assessment should have been completed and was not.

Failing to complete a skin assessment for a resident posed a risk of a worsening skin condition going undetected.

Sources: Interview with a Co-DOC, review of a resident's clinical records. **[740883]**

WRITTEN NOTIFICATION: Responsive Behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours were implemented in the home.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that the responsive behaviour program provides for written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, and is complied with.

Specifically, staff did not comply with the home's policy.

Rationale and Summary
A resident demonstrated responsive behaviours towards co-residents, staff and visitors. For a period of eight months, nine emergency codes were called due to the resident demonstrating responsive behaviours.

Review of the home's policy indicated that when a resident demonstrates a responsive behaviour, registered staff are to complete a specific assessment after meeting with the team.

The resident's clinical record indicated there was one specific assessment completed. An RPN was present for two of the nine emergency codes that were called, and acknowledged that they were not aware of the specific assessment and indicated they had never completed one before.

Failing to ensure that the home's policy was complied with posed a risk of potential behavioural triggers going unidentified.

Sources: Interview with an RPN, a resident's clinical record, the home's policy.
[740883]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee failed to ensure a resident was provided the correct diet texture that managed their dietary risks.

Rationale and Summary
A review of a resident's clinical records indicated they required specific diet interventions.

An inspector observed the resident during a meal, and a PSW was observed taking the resident's meal selection. The resident indicated to the PSW that they could not have a specific food that was being offered, due to the texture. When the resident was served, they were provided the specific food.

Following this, the inspector spoke to a Foodservice Worker (FSW) who plated the meals and they indicated that the resident's diet order was a specific texture. Inspector requested the FSW to review the master diet list and the FSW acknowledged the resident should have received a different diet texture and it was not provided.

The inspector then spoke to a PSW who served the resident their meal. The PSW indicated that the resident's diet order was a specific texture, however, after reviewing the master diet list with the inspector they acknowledged they served the incorrect texture.

Both staff indicated they did not refer to the master diet list when serving the resident.

Failing to provide the resident the correct diet order put them at risk for choking.

Sources: A resident's clinical records, observation of a resident, interview with staff, the home's policy. **[740739]**

WRITTEN NOTIFICATION: Dining and Snack Service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

3. Monitoring of all residents during meals.

The licensee failed to ensure that dining services were monitored when a resident had an incident.

Rationale and Summary
A resident had an incident during a meal. Staff wrote a note indicating they were not present when the incident occurred and left the dining room unsupervised for approximately ten minutes.

The staff indicated in an interview that it is the registered staff's responsibility to remain in the dining room to supervise until residents are completed eating.

The home's policy verified it was the registered staff's responsibility to provide supervision during meal service.

Failing to provide supervision during meal service put resident's at an increased safety risk.

Sources: A resident's clinical records, interview with a staff, the home's policy.
[740739]

WRITTEN NOTIFICATION: Administration of Drugs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use as specified by the prescriber.

Rationale and Summary
An RPN administered two separate doses of an as needed medication to a resident on the same day. Review of their clinical record indicated the order was for the medication to be given as needed once daily.

The DOC acknowledged that the medication was not administered to the resident as per the prescribers orders.

Failing to administer a drug in accordance with the directions for use as specified by the prescriber posed a risk of harm to the resident.

Sources: Interview with the DOC, a resident's clinical record. **[740883]**

WRITTEN NOTIFICATION: When Licensee May Discharge

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 157 (2)
When licensee may discharge
s. 157 (2) For the purposes of subsection (1), the licensee shall be informed by,
(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

The licensee has failed to ensure that prior to discharging a resident when they were absent from the home, they were informed by the resident's attending physician that their requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

Rationale and Summary
A resident was living in the home from an identified date until 20 months later when they were discharged. During that period, the fundamental principle of the Fixing Long Term Care Act, 2021 was applied. This meant that the long-term care home was primarily the home of the resident and was to be operated so that it was a place where they may live with dignity and in security, safety and comfort, and have their physical, psychological, social, spiritual and cultural needs adequately met.

The resident's clinical record in the home indicated on an identified date, they were sent to the hospital. That same day, the Administrator received a call from an MD at the hospital who was requesting to know if the resident would be returning to the home or not. Documentation indicated the Administrator and the DOC discussed this with the Medical Director and decided the resident would not be returning. Administrator and Medical Director acknowledged in interviews that in consultation with the DOC, they decided that the resident would be discharged from the home, as the resident's care needs had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident. The resident remained in the hospital and was absent from the home when they were discharged.

Hospital records indicated that the home refused to take the resident back. The hospital MD indicated during an interview with the inspector that they did not advise the licensee to discharge the resident. This was also verified by their documentation on the resident's hospital records.

Hospital records from the time of transfer to the time of their discharge from the home indicated that the resident was under the care of two different attending MD's. There was no documentation during that period of time that either of the attending MD's advised the licensee that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

The discharge letter provided to the resident and their SDM indicated that after the home reviewed the resident's health records and received feedback from their clinical team, they determined the resident would not be accepted back to the home and would be discharged.

The licensee did not ensure the resident was discharged according to the legislation, and in doing so, did not ensure the rights of the resident were fully respected and promoted.

Sources: Interview with a hospital MD, interview with the Administrator and DOC, interview with the Medical Director, interview with a placement co-ordinator, hospital records, a resident's clinical record, a resident's discharge letter, the home's policy. **[740883]**

WRITTEN NOTIFICATION: Resident Records

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary
On an identified date, the DOC and Resident and Family Services Coordinator (RFSC) spoke to a resident's SDM regarding consent to put the resident on a list to transfer to a different facility. The DOC documented this conversation in the residents clinical record 14 months later, identifying it as a late entry.

The DOC acknowledged that the residents clinical record was not kept up to date when the note was entered 14 months after the conversation was held.

Failing to ensure that a resident's records were kept up to date posed a risk to staff not being updated on discussions involving the residents care.

Sources: Interview with the DOC and other staff, a resident's clinical records.
[740883]

COMPLIANCE ORDER CO #001 Nutritional Care and Hydration Programs

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Educate specified staff on the home's policy, with respect to their specific responsibilities; and
2. Conduct audits twice weekly in a specified home area during a meal service for a period of four weeks to ensure a resident is provided the correct diet order. Maintain a record of the audits completed, including the staff completing the audits, dates and times audits were completed, and any corrective action taken, if necessary; and
3. Maintain a record of all education provided, including the content covered, date, signature of staff and person providing the education.

Grounds

The licensee failed to comply with their policy to provide a resident the appropriate diet texture.

In accordance with O Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the development and implementation of policies and procedures related to nutritional care, dietary services and hydration, and must be complied with.

Specifically, staff did not comply with the home's policy.

Rationale and Summary
A review of a resident's clinical records indicated the registered dietitian ordered a specified texture diet starting on an identified date.

After this date, staff documented in a note that the resident was provided a different texture diet for two meals and the resident did not have any incidents.

On another date, staff documented in a note that the resident was provided a different texture diet and no concerns were noted.

On another date, staff completed a referral to the RD that included documentation that the resident was doing well with the texture that staff were providing and was refusing the ordered diet texture.

During an interview, two staff both verified that Registered Nursing staff had the ability to upgrade resident diet texture if they felt it was appropriate.

During an interview, an RPN verified they were able to assess a resident for an upgrade in diet texture and referenced the resident as an instance when this occurred.

The home's policy indicated that registered staff may go down in a texture but never upgrade in a texture without consulting the Registered Dietitian or Medical Director, and PSW's will follow the Master diet list orders.

Failing to comply with the home's policy for therapeutic diet orders and upgrading a resident's diet put them at risk of harm.

Sources: A resident's clinical records, the home's policy, interview with staff.
[740739]

This order must be complied with by April 8, 2024.

COMPLIANCE ORDER CO #002 Requirements on Licensee Before Discharging a Resident

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 161 (2)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where

appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Educate the Administrator, Director of Care and Medical Director on s. 161 (2) of O. Reg. 246/22 and the home's policy on discharge. The education must be conducted by a member of the licensee's head office; and
2. Keep a record of the education, including the date it was held, who conducted the education and signatures of those that attended indicating they understood the education, for the LTCH inspector to review.

Grounds

The licensee has failed to ensure that before discharging a resident, the proper legislative requirements were followed.

Rationale and Summary

i) According to O. Reg. 246/22 s. 161 (2) (b), a licensee is required to collaborate with an appropriate placement co-ordinator and other health service organizations to make alternative arrangements for the accommodation of a resident prior to discharging them.

A resident was discharged from the home on an identified date. The discharge letter indicated the home was unable to accommodate the residents return to the home and was hopeful that the Home and Community Care Support Services (HCCSS) could accommodate their care needs at another home or another appropriate medical setting and indicated for the resident and their SDM to contact HCCSS.

The home's placement co-ordinator for the HCCSS acknowledged that the home had contacted them to inform them they would be discharging the resident from the home, and indicated that they were currently in the hospital. The placement co-ordinator advised the home they needed to ensure they followed the legislative requirements regarding discharge, and that since the resident was currently in the hospital, it would be the hospital's responsibility to find them an alternative accommodation.

The manager for HCCSS indicated that the resident's file was closed with them when they were admitted to the home, therefore they were not involved in the discharge process.

ii) According to O. Reg. 246/22 s. 161 (2) (c), prior to discharging a resident a licensee is required to ensure that the resident and their SDM is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration.

A resident was sent to the hospital on an identified date. One day later, the Administrator acknowledged that they phoned the SDM to notify them that the

resident would be discharged from the home, and set up a time to have a discharge meeting.

During the discharge meeting, the SDM indicated that they were informed by the hospital that the resident would not be returning to the home, prior to the home informing them. The SDM and their family expressed that they felt that the home's team did not include them in the process. The specified MD, who had been following the resident in the home, apologized for the lack of communication and indicated there were certain gaps that were identified.

Review of the discharge letter provided to the resident and their SDM indicated that the home was unable to approve the residents re-admission and provided the number for HCCSS for the SDM to contact.

Failing to ensure that prior to discharging a resident, their SDM was included in the discharge process, as well as ensuring the appropriate placement co-ordinator and health service organizations were collaborated with, posed a risk of harm to the resident's well-being.

Sources: Interview with the Administrator and other staff, interview with a placement co-ordinator for HCCSS, interview with a manager for HCCSS, interview with a hospital social worker, a resident's clinical record, a discharge letter, audio file, the home's policy, hospital records. **[740883]**

This order must be complied with by April 1, 2024.

COMPLIANCE ORDER CO #003 Directives by Minister

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational

or policy directive that applies to the long-term care home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Educate specified staff on high touch cleaning policy including frequency of cleaning during outbreak; and
2. Maintain a record of the education provided, including the content covered, date, signature of the staff, and the person providing the education; and
3. Conduct daily visual audits for high touch cleaning frequency completed by the specified staff during outbreak for the entirety of the next outbreak that applies to these staff. Maintain a record of all audits completed, including the staff completing the audit, dates and times of audits that were completed, and any corrective actions taken, if necessary.

Grounds

The licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 2022, where environmental cleaning was not followed by housekeeping staff during outbreaks.

Rationale and Summary
In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated November 7, 2023, cleaning and disinfecting of high touch surfaces were not performed more than once daily during outbreak.

The home's outbreak checklist indicated that during outbreak high touch surfaces were to be cleaned/disinfected at least twice daily.

In separate interviews, three housekeeping staff all indicated that during outbreak their cleaning frequency of high touch surfaces did not differ from their usual practice of once daily. A staff was interviewed while they were completing housekeeping duties in an outbreak area of the home and verified with the inspector that they would clean the high touch surfaces once during their shift.

Failing to clean/disinfect high touch surfaces more than once daily during outbreak places residents at risk of infectious disease spread and prolongation of outbreaks.

Sources: home's outbreak management checklist/plan, interviews with staff.
[740739]

This order must be complied with by April 29, 2024.

COMPLIANCE ORDER CO #004 Infection Prevention and Control Program

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Educate staff specified staff on selecting and applying the appropriate Personal Protective Equipment (PPE) for additional precautions; and
2. Conduct audits twice weekly for PPE donning and doffing for the specified staff for a period of two weeks. Maintain a record of all audits completed,

including the staff completing the audit, dates and times audits were completed, and any corrective action taken, if necessary; and

3. Maintain a record of all education provided, including the content covered, date, signature of the staff and the person providing the education; and
4. Create a plan/process to ensure 2024 annual risk assessment training for routine and additional precautions, as required by Additional Requirement 6.3 under the Infection Prevention and Control (IPAC) Standard is completed by all staff by the required date; and
5. Maintain a record of this plan, including dates, and staff responsible for ensuring training is complete.

Grounds

A) The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes was implemented.

Specifically, staff did not ensure that residents were supported to perform hand hygiene prior to meals as required by Additional Requirement 10.4 (h) under the IPAC Standard.

Rationale and Summary
A meal service was observed on a home area. Staff were observed transporting residents to the dining room. A PSW and RPN each transported a resident to the dining room. The residents were not offered or assisted with hand hygiene before their meal. Following this, two residents independently transported themselves to the dining room. The residents sat at their tables and were provided their meals. Staff did not offer or encourage hand hygiene to these residents.

A Co-DOC indicated to the inspector that staff should be providing or encouraging hand hygiene for residents upon entry to the dining room or at their tables prior to meals.

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

The home's hand hygiene policy indicated that staff are to clean or assist residents with appropriate hand sanitizer or cleaning wipes before and after meals.

Not completing resident's hand hygiene prior to meals may have increased transmission of infections.

Sources: observations, interview with staff, the home's policy. **[740739]**

B) The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes was implemented.

Specifically, staff did not select and apply the appropriate PPE as required by Additional Requirement 9.1 (f) under the IPAC Standard.

Rationale and Summary
Two staff were observed inside a resident's room. Signage was posted on the wall outside the room that the resident was on specified precautions indicating that gloves and gown were required. A cart containing PPE was outside the door. Both staff were observed wearing gloves inside the room while providing care.

When care was complete inspector asked both staff what PPE was required when providing care for this resident. Both staff indicated that they were toileting the resident and that a gown and gloves were required. Both staff acknowledged that a gown was not applied for care.

Failing to select and apply the appropriate PPE may have increased risk of transmission of infection.

Sources: Observation, interview with staff. **[740739]**

C) The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes was implemented.

Specifically, staff did not select and apply the appropriate PPE as required by Additional Requirement 9.1 (f) under the IPAC Standard.

Rationale and Summary
A resident's room has signage in place indicating they were on specific precautions. A staff member was observed in the resident's room, wearing a surgical mask and gown while providing the resident a drink and standing next to them. Resident was observed coughing during observation.

The inspector asked what PPE was to be worn when they were within two metres of the resident in their room. The staff indicated they were wearing the appropriate PPE at the time of the observation.

Inspector spoke with IPAC Lead and they verified the staff in the room should be wearing gown, gloves, face shield and N95 mask.

Failing to know the appropriate PPE can increase risk of transmission of infections to other residents.

Sources: observation, interview with staff. **[740739]**

D) The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes was implemented.

Specifically, the licensee failed to ensure training was completed by all staff on risk assessment for routine and additional precautions as required by Additional Requirement 6.3 under the IPAC Standard.

Rationale and Summary
Training records were reviewed for 2023 IPAC education. According to training records, 87.5 percent (%) of staff completed education on risk assessment for routine and additional precautions.

The IPAC lead verified that all staff must complete this education.

Failing to complete the required education for risk assessment for routine and additional precautions may result in staff not selecting the appropriate PPE when completing care, which could put residents at higher risk of spread of infectious disease.

Sources: Training records for IPAC education, 2023, interview with staff. **[740739]**

This order must be complied with by April 29, 2024.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following

to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.